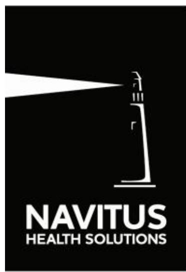


TEXAS MEDICAID
Clinical Edit Prior Authorization

pioglitazone (ACTOS), pioglitazone/metformin (ACTOPLUS MET), pioglitazone/glimepiride (DUETACT)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: ______________________________________ ICD 10 Code: ___________

Indicate the drug's formulary status: *(Formulary available at www.txvendordrug.com)

☐ Non-Preferred Drug **(NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ Preferred Drug **(Go to Step 4)**

OR ☐ N/A as this request is for a CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the last 180 days?

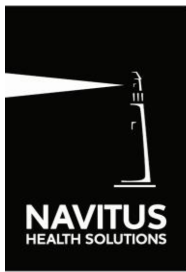
   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)



STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Does the client have a diagnosis of heart failure in the last 365 days?

   ☐ Yes (Go to # 2) ☐ No (Go to #3)

2. Does the client have a history of two (2) heart failure drugs for 30 days in the last 90 days?

   Examples of heart failure drugs include BIDIL, bumetanide (BUMEX), CORLANOR, digoxin (LANOXIN), ENTRESTO, eplerenone (INSPRA), ethacrynic acid, furosemide (LASIX), and torsemide.

   ☐ Yes (Deny) ☐ No (Go to #3)

3. Does the client have a diagnosis of Type II Diabetes in the last 730 days?

   ☐ Yes (Go to #4) ☐ No (Deny)

4. Does the client have a history of a metformin-containing agent for 30 days in the last 730 days?

   ☐ Yes (Approve - 365 days)
   ☐ If No, and drug is in Table 1 (Deny)
   ☐ If No, and drug is in Table 2 (Go to #5)

5. Does the client have a diagnosis of renal failure in the last 730 days?

   ☐ Yes (Approve - 365 days) ☐ No (Deny)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: 855-668-8553

Prescriber Signature: ____ **Date:** ____________

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.

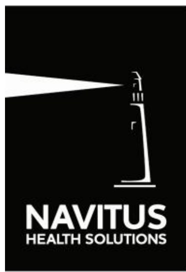


TABLE 1
ACTOPLUS MET 15 MG-500 MG TAB
ACTOPLUS MET XR 15-1,000 MG TB
ACTOPLUS MET XR 30-1,000 MG TB
PIOGLITAZONE-METFORMIN 15-500
PIOGLITAZONE-METFORMIN 15-850

TABLE 2	
ACTOS 15 MG TABLET	PIOGLITAZONE HCL 15 MG TABLET
ACTOS 30 MG TABLET	PIOGLITAZONE HCL 30 MG TABLET
ACTOS 45 MG TABLET	PIOGLITAZONE HCL 45 MG TABLET
ALOGLIPTIN-PIOGLIT 12.5-15	PIOGLITAZONE-GLIMEPIRIDE 30-2
ALOGLIPTIN-PIOGLIT 12.5-30	PIOGLITAZONE-GLIMEPIRIDE 30-4
ALOGLIPTIN-PIOGLIT 12.5-45	
ALOGLIPTIN-PIOGLIT 25-15	
ALOGLIPTIN-PIOGLIT 25-30	
ALOGLIPTIN-PIOGLIT 25-45	
DUETACT 30-2 MG TABLET	
DUETACT 30-4 MG TABLET	